DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

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In reply to: 176

May 17, 2001

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

VA'S ROLE IN TRICARE FOR LIFE

1. TRICARE for Life (TFL) legislation (Fiscal Year 2002 National Defense Authorization Act, Public Law 106-398) expands TRICARE benefits to cover all retirees, spouses and survivors aged 65 and older who are eligible for Medicare Part A (for hospitalization payments) and enrolled in Medicare Part B (for other provider payments). TFL is scheduled to take effect on October 1, 2001. Based on Department of Defense (DOD) data, TFL will cover approximately 785,000 retirees, 391,000 spouses and dependents, and 214,000 survivors who are 65 years old and older.

2. Eligible beneficiaries will receive all Medicare-covered benefits under Medicare Standard plus all TRICARE-covered benefits. For most beneficiaries who use a Medicare provider, Medicare will be first payer for all Medicare-covered services and TRICARE Standard will be second payer. TRICARE will pay all Medicare copays and deductibles and cover most of the cost of certain care not covered by Medicare. TRICARE beneficiaries must pay the Medicare Part B yearly deductible.

3. Department of Veterans Affairs (VA) medical centers do not qualify for Medicare payments since they are Government providers. Draft language under consideration for inclusion in the Managed Care Support Contractor (MCSC) Manual (6010.49.49-M, March 2001) addresses VA medical centers' role as providers (see Att. A). TRICARE would be the primary payer assessing any applicable deductibles or cost sharing for VA facilities.

4. The level of reimbursement for VA medical centers apparently depends on the VA medical centers' TRICARE provider status (i.e., whether the VA facility was a TRICARE network or non-network provider). Network providers would be fully reimbursed at negotiated rates. Non-network VA providers would be reimbursed, at lesser rates, in the same manner as other non-network providers. Many issues need to be resolved including the reimbursement rates for VA facilities. It appears that it will be advantageous for VA medical centers to become network providers in order to receive full, direct TRICARE reimbursement. It also appears that it would be advantageous for VA facilities to make improvements, wherever necessary, in their current billing software to permit fully automated TRICARE reimbursement requests to maximize revenue potential.

5. The draft MCSC contract requirements relating to VA facilities are among many changes made necessary by TFL, which are still under discussion within DOD. Even when the "Interim Final Rule" is published a formal comment period must be allotted. This process will be completed only after a "Final Rule" is published. Final publication may not occur until the end of the fiscal year.

6. The Medical Sharing Office (176) will continue to monitor DOD's progress on the draft MCSC contract requirements. The Office of Finance (17) will seek to engage offices within VHA as appropriate. For further information contact James E. Simmons, VA-DOD Sharing Program Manager, by Exchange or at (202) 273-8411.

S/ Frances Murphy, M.D. for
Thomas L. Garthwaite, M.D.
Under Secretary for Health

Attachment

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ATTACHMENT A

MANAGED CARE SUPPORT CONTRACTOR (MCSC) OPERATIONS MANUAL 6010.49-M, MAR 2001
DOUBLE COVERAGE

CHAPTER 9
SECTION 4

SPECIFIC DOUBLE COVERAGE ACTIONS

1.0. TRICARE AND MEDICARE

1.1. Medicare Always Primary to TRICARE

Certain persons over 65 years of age who were not previously entitled to Medicare Part A, "Hospital Insurance Benefits," became eligible to enroll in Part A after June 30, 1973, under the premium Health Insurance provision of the 1972 Amendment to the Social Security Act. Entitlement to Part A secured under these circumstances does not result in a loss of TRICARE benefits. With the exception of services provided by a resource sharing provider in an MTE in any double coverage situation involving Medicare and TRICARE, Medicare is always primary. When services are provided by a resource sharing provider in a MTF, the double coverage procedures are waived and TRICARE is primary payer. This applies only to Medicare. All other payers remain primary to TRICARE.

1.2. Services Provided Prior to October 1, 2001. All services provided prior to October 1, 2001, on which Medicare is the primary payer are to be processed using the procedures described in Section 3 of this chapter.

1.3. Coordination with Part A, Medicare. Virtually all Part A, Medicare, claims are submitted by participating providers. Because of the Part A payment mechanisms, the provider knows, at the time the claim is submitted, the amount that will not be paid by Medicare. This amount is then billed to the beneficiary or to the beneficiary's secondary coverage. It is this amount that TRICARE will pay along with any services denied by Medicare, which are covered by TRICARE. In cases where the TRICARE allowable amount (or the negotiated rate) is less than the Medicare payment, the beneficiary will have no liability for the Medicare deductible and coinsurance. When the beneficiary has exhausted his or her Part A benefits for a benefit period, TRICARE will pay the full benefit amount for covered services.

1.4. Coordination with Part B, Medicare. With the exception of prescription drug claims, which are not a Medicare benefit, a TRICARE claim must be accompanied by a copy of the appropriate "Explanation of Medicare Benefits" (EOMB) form. When Medicare paid its benefits directly to the beneficiary, the secondary share paid by TRICARE will be calculated according to the procedures in Chapter 9, Section 3, paragraph 2.0. When Medicare paid benefits directly to the provider, TRICARE may pay only the Medicare deductible, Medicare coinsurance, and any

services which were denied by Medicare and which are covered by TRICARE. In cases where the TRICARE allowable amount (or the negotiated rate) is less than the Medicare payment, the beneficiary will have no liability for the Medicare deductible and coinsurance. TRICARE may not pay the difference between the billed charge and the Medicare allowed charge, since to do so would place the provider in violation of Medicare's assignment agreement.

1.5. Services Provided on or after October 1, 2001. As of October 1, 2001, TRICARE beneficiaries who reach ago 65 do not lose TRICARE eligibility if they are enrolled in Medicare Part B. Special double coverage procedures are to be used for these claims in order to minimize out-of-pocket expenditures for these beneficiaries. These special procedures are to be used for all claims for beneficiaries who are eligible for Medicare, including active duty dependents who are age (35 and over as well as those beneficiaries under age 65 who are eligible for Medicare. The following sections set forth the amounts that TRICARE will pay if the beneficiary is covered by Medicare and TRICARE. If a third coverage is involved, TRICARE will be last payer (see the Policy Manual. Chapter 1.3, Section 12.1) and payments by the third coverage will reduce the amounts of TRICARE payment that are set forth below. In all cases where TRICARE is the primary payer, all claims processing requirements (such as application of TRICARE Claimcheck are to be followed.

1.5.1. Services that are a benefit under both Medicare and TRICARE

1.5.1.1. If the service or supply is a benefit under both Medicare and TRICARE, the beneficiary will have no out-o f-pocket expenses. For these claims TRICARE will resemble a Medicare supplement. That is, the allowable amount under Medicare will be used as the TRICARE allowable, and TRICARE payment will equal the remaining beneficiary liability after Medicare processes the claim without regard to any TRICARE deductible and cost-share amounts that would otherwise be assessed. For example, if it is the first claim of the year and the billed charge is $50) (which is also the amount both Medicare and TRICARE allow on the claim), Medicare will apply the entire amount to the Medicare deductible and pay nothing. In this case, TRICARE will pay the full $50 so that the beneficiary has no out of pocket expense. Similarly, if Medicare pays an amount that is greater than what TRICARE normally would allow for a network provider, TRICARE will still pay any Medicare deductible and cost-sharing amounts, even if that represents payments in excess of the normal TRICARE allowable amount.

NOTE: *It is not necessary for the contractor to price these claims, since the Medicare allowable becomes the TRICARE allowable, and TRICARE payment is based on the remaining beneficiary liability. The contractor need only verify eligibility and coverage in processing the claim. Contractors will not be required to duplicate Medicare's provider certification, medical necessity. Referral, authorization, and potential duplicate editing.*

1.5.1.2 If the service or supply normally is a benefit under both Medicare and TRICARE but Medicare cannot make any payment because the beneficiary has exhausted Medicare benefits, CHAMPUS will make payment as the primary payer assessing all applicable deductibles and cost-shares. For example, TRICARE is primary payer for inpatient care beyond 150 days.

1.5.1.3. If the service or supply normally is a benefit under both Medicare and TRICARE, but

Medicare cannot make any payment because the beneficiary lives overseas where Medicare will not make any payment, TRICARE will process the claim as a primary payer with any applicable deductibles and cost-shares. Since the contractor knows that Medicare cannot make any payment on such claims, the contractor can process the claim without evidence of processing by Medicare. Even though Medicare cannot make payment overseas, beneficiaries living overseas must still purchase Part B of Medicare in order to maintain their TRICARE eligibility.

1.5. 1.4. If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare does not make any payment because the service or supply is not medically necessary, TRICARE cannot make any payment on the claim. In such cases, the contractor is to return the claim to the beneficiary indicating that the beneficiary must file an appeal with Medicare. If Medicare subsequently reverses its medical necessity denial, Medicare will make payment on the claim and it can then be submitted to TRICARE for payment of any remaining beneficiary liability. If Medicare does not reverse its medical necessity denial, the claim cannot be submitted to TRICARE.

1.5.2. Services that are a benefit under Medicare but not under TRICARE. TRICARE will make no payment for services and supplies that are not a benefit under TRICARE, regardless of any action Medicare may take on the claim.

1.5.3. Services that are a benefit under TRICARE but not under Medicare. If the service or supply is a benefit under TRICARE but not under Medicare, TRICARE will process the claim as the primary payer assessing any applicable deductibles and cost -shares. If the contractor knows that a service or supply on the claim is not a benefit under Medicare, the contractor can process the claim without evidence of processing by Medicare for that service or supply.

1.5.4. Services that are provided in a non-DOD government facility. If services or supplies are provided in a non-DOD government facility such as a Veterans Administration Hospital, Medicare will make no payment. In such cases TRICARE will make payment as the primary payer assessing all applicable deductibles and cost-shares.

2.0. TRICARE AND MEDICAID

Medicaid is not considered a double coverage plan. When a TRICARE beneficiary is also eligible for Medicaid, TRICARE is always primary for all classes of beneficiary. If Medicaid erroneously pays benefits as a primary payer on behalf of a TRICARE beneficiary, the contractor will reimburse the state Medicaid agency. See the Policy Manual, Chapter 13, Section 5.1.

3.0. MATERNAL AND CHILD HEALTH PROGRAM/INDIAN HEALTH SERVICE

Eligibility for health benefits under either of these two Federal programs is not considered to be double coverage. (See the Policy Manual, Chapter 13, Section 12.1.)

4.0. TRICARE AND VETERANS ADMINISTRATION

Eligibility for health care through the Veterans Administration for a service-connected disability is not considered double coverage. The beneficiary may choose to use either TRICARE or Veterans benefits, providing the beneficiary is TRICARE eligible. (The VA sponsor of a TRICARE beneficiary is not eligible for care under either TRICARE or CHAMPVA.) However, TRICARE will not duplicate payments made by, or authorized to be made, by the Veterans Administration for treatment of a service-connected disability.